

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038455</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Alden Village Health Facility</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>267 E. Lake Street</u> <u>Bloomington</u> <u>60108</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>DuPage</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Steven M. Kroll</u> (Title) <u>Chief Financial Officer</u>	
Telephone Number: <u>(630)529-3350</u> Fax # <u>(630)529-9866</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
IDPA ID Number: <u>36-3845800</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>11/02/92</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773)286-3883</u>			

Facility Name & ID Number Alden Village Health Facility# 0038455 Report Period Beginning: 01/01/2001 Ending: 12/31/2001**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>35,767</u>	<u>393</u>	<u>202</u>	<u>36,362</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,767</u>	<u>393</u>	<u>202</u>	<u>36,362</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.40%

D. How many bed-hold days during this year were paid by Public Aid?

695 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
_____F. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/92

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Alden Village Health Facility

0038455

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	158,882	15,815		174,697	1,117	175,814		175,814			1
2	Food Purchase		520,233		520,233	(22,042)	498,191	(303,973)	194,218			2
3	Housekeeping	153,999	21,897		175,896	270	176,166		176,166			3
4	Laundry	82,904	14,267		97,171		97,171		97,171			4
5	Heat and Other Utilities			96,237	96,237		96,237		96,237			5
6	Maintenance	46,439		64,496	110,935	1,100	112,035	6,412	118,447			6
7	Other (specify):*											7
8	TOTAL General Services	442,224	572,212	160,733	1,175,169	(19,555)	1,155,614	(297,561)	858,053			8
	B. Health Care and Programs											
9	Medical Director			29,660	29,660		29,660		29,660			9
10	Nursing and Medical Records	2,171,202	157,297	(10,241)	2,318,258	6,018	2,324,276	3,987	2,328,263			10
10a	Therapy			97,489	97,489	1,415	98,904	10,538	109,442			10a
11	Activities	62,512	2,776	3,623	68,911		68,911		68,911			11
12	Social Services			127,574	127,574		127,574		127,574			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,233,714	160,073	248,105	2,641,892	7,433	2,649,325	14,525	2,663,850			16
	C. General Administration											
17	Administrative	105,518			105,518		105,518		105,518			17
18	Directors Fees											18
19	Professional Services			693,515	693,515		693,515	(510,602)	182,913			19
20	Dues, Fees, Subscriptions & Promotions			32,386	32,386	(1,100)	31,286	(25,974)	5,312			20
21	Clerical & General Office Expenses	326,299	11,627	15,380	353,306	1,063	354,369	82,650	437,019			21
22	Employee Benefits & Payroll Taxes			371,136	371,136	12,159	383,295	40,538	423,833			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,221	10,221	(7,250)	2,971	7,982	10,953			24
25	Other Admin. Staff Transportation			71,642	71,642		71,642		71,642			25
26	Insurance-Prop.Liab.Malpractice			59,701	59,701		59,701	(2,517)	57,184			26
27	Other (specify):* Bad debt recovery			(39,961)	(39,961)		(39,961)	39,961				27
28	TOTAL General Administration	431,817	11,627	1,214,020	1,657,464	4,872	1,662,336	(367,962)	1,294,374			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,107,755	743,912	1,622,858	5,474,525	(7,250)	5,467,275	(650,998)	4,816,277			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Village Health Facility

#0038455

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			38,261	38,261		38,261	107,069	145,330			30
31	Amortization of Pre-Op. & Org.							7,863	7,863			31
32	Interest			127,398	127,398		127,398	305,704	433,102			32
33	Real Estate Taxes							49,315	49,315			33
34	Rent-Facility & Grounds			639,578	639,578		639,578	(639,172)	406			34
35	Rent-Equipment & Vehicles			8,614	8,614	7,250	15,864	15,158	31,022			35
36	Other (specify):* Mortgage insurance							26,993	26,993			36
37	TOTAL Ownership			813,851	813,851	7,250	821,101	(127,070)	694,031			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,240	40,809	44,049		44,049	(6,021)	38,028			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			355,774	355,774		355,774		355,774			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		3,240	396,583	399,823		399,823	(6,021)	393,802			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,107,755	747,152	2,833,292	6,688,199		6,688,199	(784,089)	5,904,110			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,702)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(120)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(993)	32		18
19	Entertainment	(14,051)	20		19
20	Contributions	(2,803)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	39,961	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,645)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 3,647		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(788,694)	Various	34
35	Other- Attach Schedule	958	Various	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (787,736)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (784,089)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Village Health Facility

ID# 0038455

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Self insurance adjustment	\$ (3,161)	26	1
2	Miscellaneous income	(64)	21	2
3	Eliminate PAC costs from IHCA dues	(523)	21	3
4	HMO Contractual	(5,747)	39	4
5	Adjust facility real estate taxes to paid	356	33	5
6	Eliminate credit on dental exams	13,607	10	6
7	insurance expense adjustment (\$29 x 109 bed fac)	(3,161)	26	7
8	back out Illinois healthcare pac fees on p. 5A	(349)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	958		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(120)	0	0	(303,853)	0	0	0	0	0	0	0	(303,973)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	6,467	0	0	0	(55)	0	0	0	0	6,412	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(120)	0	6,467	(303,853)	0	0	(55)	0	0	0	0	(297,561)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	13,607	0	0	(7,405)	0	(2,215)	0	0	0	0	0	3,987	10
10a	Therapy	0	0	0	0	0	10,538	0	0	0	0	0	10,538	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	13,607	0	0	(7,405)	0	8,323	0	0	0	0	0	14,525	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,388	(516,990)	0	0	0	0	0	0	0	0	(510,602)	19
20	Fees, Subscriptions & Promotions	(18,848)	0	(7,126)	0	0	0	0	0	0	0	0	(25,974)	20
21	Clerical & General Office Expenses	(587)	0	18,721	64,142	0	374	0	0	0	0	0	82,650	21
22	Employee Benefits & Payroll Taxes	0	0	40,461	0	0	77	0	0	0	0	0	40,538	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,982	0	0	0	0	0	0	0	0	7,982	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(6,322)	3,805	0	0	0	0	0	0	0	0	0	(2,517)	26
27	Other (specify):*	39,961	0	0	0	0	0	0	0	0	0	0	39,961	27
28	TOTAL General Administration	14,204	10,193	(456,952)	64,142	0	451	0	0	0	0	0	(367,962)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	27,691	10,193	(450,485)	(247,116)	0	8,774	(55)	0	0	0	0	(650,998)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(16,702)	111,822	11,855	0	0	94	0	0	0	0	0	107,069	30
31	Amortization of Pre-Op. & Org.	0	6,549	150	0	0	1,164	0	0	0	0	0	7,863	31
32	Interest	(993)	404,132	(99,672)	0	0	2,237	0	0	0	0	0	305,704	32
33	Real Estate Taxes	356	44,695	4,240	0	0	24	0	0	0	0	0	49,315	33
34	Rent-Facility & Grounds	0	(639,578)	406	0	0	0	0	0	0	0	0	(639,172)	34
35	Rent-Equipment & Vehicles	0	0	15,158	0	0	0	0	0	0	0	0	15,158	35
36	Other (specify):*	0	26,993	0	0	0	0	0	0	0	0	0	26,993	36
37	TOTAL Ownership	(17,339)	(45,387)	(67,863)	0	0	3,519	0	0	0	0	0	(127,070)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(5,747)	0	0	0	0	(274)	0	0	0	0	0	(6,021)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(5,747)	0	0	0	0	(274)	0	0	0	0	0	(6,021)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	4,605	(35,194)	(518,348)	(247,116)	0	12,019	(55)	0	0	0	0	(784,089)	45

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See Page 6K		See page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rental Income	\$ 639,578	Alden Village II, Inc	100.00%	\$	\$ (639,578)
2	V	32 Interest Income	3,736	Alden Village II, Inc			(3,736)
3	V	32 Misc. Income	16,392	Alden Village II, Inc			(16,392)
4	V	33 Real Estate Taxes		Alden Village II, Inc		44,695	44,695
5	V	26 Insurance		Alden Village II, Inc		3,805	3,805
6	V	32 Interest of Mortgage		Alden Village II, Inc		424,260	424,260
7	V	36 Mortgage Ins. Prem.		Alden Village II, Inc		26,993	26,993
8	V	19 Misc. G & A		Alden Village II, Inc		6,388	6,388
9	V	30 Depreciation		Alden Village II, Inc		111,822	111,822
10	V	31 Amortization		Alden Village II, Inc		6,549	6,549
11	V						
12	V						
13	V						
14	Total		\$ 659,706			\$ 624,512	\$ * (35,194)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Benefits	\$	Alden Management Services, Inc.	100.00%	\$ 40,461	\$ 40,461 15
16	V	19 Management fees	524,024	Alden Management Services, Inc.		7,034	(516,990) 16
17	V	21 Gen'l & Admin.		Alden Management Services, Inc.		18,721	18,721 17
18	V	6 maintenance/utilities		Alden Management Services, Inc.		6,467	6,467 18
19	V	24 autos/seminars		Alden Management Services, Inc.		7,982	7,982 19
20	V	20 dues/subscriptions		Alden Management Services, Inc.		194	194 20
21	V	30 depreciation		Alden Management Services, Inc.		11,855	11,855 21
22	V	31 amortization		Alden Management Services, Inc.		150	150 22
23	V	33 real estate tax		Alden Management Services, Inc.		4,240	4,240 23
24	V	34 rent		Alden Management Services, Inc.		406	406 24
25	V	35 rent-equip/vehicles		Alden Management Services, Inc.		15,158	15,158 25
26	V	32 interest	123,198	Alden Management Services, Inc.		23,526	(99,672) 26
27	V	20 Marketing fees	7,320	Alden Management Services, Inc.			(7,320) 27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 654,542			\$ 136,194	\$ * (518,348) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	TUBE FEEDINGS	\$ 372,538	PYRAMID HEALTH CARE SERVICES	100.00%	\$ 68,685	\$ (303,853)	15
16	V	10	NURSING SUPPLIES	15,123	PYRAMID HEALTH CARE SERVICES		7,718	(7,405)	16
17	V	39	SUPPLIES / PER DIEM FEES		PYRAMID HEALTH CARE SERVICES				17
18	V	21	GENERAL & ADMIN.		PYRAMID HEALTH CARE SERVICES		64,142	64,142	18
19	V				PYRAMID HEALTH CARE SERVICES				19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 387,661			\$ 140,545	\$ * (247,116)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A OT/ST/PT Rehab	\$ 97,489	COMMUNITY PHYSICAL THERAPY	100.00%	\$ 108,027	\$ 10,538	15
16	V	31 AMORTIZATION		COMMUNITY PHYSICAL THERAPY		1,164	1,164	16
17	V	32 INTEREST		COMMUNITY PHYSICAL THERAPY		2,094	2,094	17
18	V	39 Respiratory Therapy	34,780	COMMUNITY PHYSICAL THERAPY		35,207	427	18
19	V	10 Nursing Supplies	10,233	FORUM EXTENDED CARE SERVICES, INC.	100.00%	8,018	(2,215)	19
20	V	22 Taxes and fringe benefits		FORUM EXTENDED CARE SERVICES, INC.		77	77	20
21	V	21 office expense		FORUM EXTENDED CARE SERVICES, INC.		374	374	21
22	V	32 interest		FORUM EXTENDED CARE SERVICES, INC.		143	143	22
23	V	33 Real estate taxes		FORUM EXTENDED CARE SERVICES, INC.		24	24	23
24	V	30 Depreciation		FORUM EXTENDED CARE SERVICES, INC.		94	94	24
25	V	39 Drugs	3,240	FORUM EXTENDED CARE SERVICES, INC.		2,539	(701)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 145,742			\$ 157,761	\$ * 12,019	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 maintenance expense	\$ 8,759	Alden Bennett Construction	100.00%	\$ 8,704	\$ (55)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 8,759			\$ 8,704	\$ * (55)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A Schlossberg	President/CFO		100.00	347,656	2.148	3.58	Salary	\$ 12,895	28	1
2	Lauren Magnusson	Clinical Coordinator		A	77,824	1.611	3.58	Salary	2,887	32	2
3	Terry Magnussen	Maintenance Supr		A	71,101	1.611	3.58	Salary	2,637	32	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,419		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.

Street Address 4200 W. Peterson Avenue

City / State / Zip Code Chicago, IL 60646

Phone Number (773 286-6622

Fax Number (773 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See Page 8A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Cambridge Realty Capital		X	Mortgage	\$39,067.00		\$ 5,983,300	\$ 5,871,937	4/2034	7.2000	\$ 424,260	1	
2												2	
3												3	
4												4	
5	US Treasury			payroll taxes							3,207	5	
	Working Capital												
6	RELATED PARTY - CPT	X		OPERATIONS	NONE					VARIES	2,094	6	
7	RELATED PARTY - AMS	X		OPERATIONS	NONE					VARIES	23,526	7	
8	Related Party-Forum	X		Operations	NOne					Varies	143	8	
9	TOTAL Facility Related				\$39,067.00		\$ 5,983,300	\$ 5,871,937			\$ 453,230	9	
	B. Non-Facility Related*												
10	INTEREST INCOME										(20,128)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (20,128)	14	
15	TOTALS (line 9+line14)						\$ 5,983,300	\$ 5,871,937			\$ 433,102	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number Alden Village Health Facility

0038455 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$	47,000	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	45,170	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,830)	3	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	46,881	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	45,051	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	41,347	8		
	1997	43,638	9		
	1998	44,481	10		
	1999	44,594	11		
	2000	44,695	12		
2001 Accrual is based on 1.04% of 2000 tax bill.				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Village Health Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0038455

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773)286-6622 FAX #: 773 286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02-14-107-028</u>	<u>Nursing home</u>	\$ <u>42,157.04</u>	\$ <u>42,157.04</u>
2. <u>02-14-107-027</u>	<u>Nursing home</u>	\$ <u>3,012.86</u>	\$ <u>3,012.86</u>
3. _____	<u>Related party-Alden Management</u>	\$ <u>118,551.00</u>	\$ <u>4,264.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>163,720.90</u></u>	\$ <u><u>49,433.90</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
30,726

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
1

C. Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building		1992	\$ 135,758	1
2					2
3	TOTALS			\$ 135,758	3

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-AMS			1978	\$ 18,359	\$	22	\$		\$ 18,359	4
5	Related Party-Forum		1999		240	11	40	11		20	5
6	109		1992	1973	639,042		30	21,301	21,301	582,530	6
7			1984	1984	706,283	84,991	15	47,086	(37,905)	793,700	7
8											8
	Improvement Type**										
9	Repair Heater pump, replace temp controller		1992		2,131	213	10	213		1,935	9
10	Water heater moyor; valve repair		1993		9,288	409	5-15	409		8,298	10
11	Carpentry work, water heater repair		1994		63,064	2,937	3-15	2,937		43,161	11
12	Fire alarm repairs; brickwork; install circuits		1995		185,123	10,689	3-25	10,689		79,521	12
13	Village construction		1996		14,046	562	25	562		3,793	13
14	Install fire door		1996		2,977	198	15	198		1,157	14
15	Replace compressor		1997		1,825	365	5	365		1,643	15
16	Roof patching		1998		1,700	170	10	170		623	16
17	Replace condensing unit		1998		4,810	321	15	321		1,123	17
18	install damper motor & detector		1998		2,104	140	15	140		456	18
19	Replace furnace equipment		1999		1,827	122	15	122		366	19
20	install automatic door		1999		8,107	811	10	811		1,892	20
21	Install display and digital phones		2000		1,726	173	10	173		245	21
22	Replace HVAC burners		2000		1,607	536	3	536		1,072	22
23	Replace 5 ton condensing unit		2000		1,950	390	5	390		650	23
24	Install 100 amp disconnect and cable		2000		1,920	384	5	384		644	24
25	Roof repair		2000		1,583	312	5	312		365	25
26	Door Alarms		2001		19,015	951	10	951		951	26
27	Display phone and digital phone		2001		1,609	149	10	149		149	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Related Party-Forum:		\$	\$		\$	\$	\$		37
38	Leasehold Improvement-Remodeling	1980	19,335		20			19,335		38
39	Leasehold Improvement-Remodeling	1980	1,208		10			1,208		39
40	Leasehold Improvement-Remodeling	1986	645		5			645		40
41	Leasehold Improvement-Remodeling	1990	404		5			404		41
42	Leasehold Improvement-Remodeling	1991	94		5			94		42
43	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		7,474		43
44	Leasehold Improvement-Remodeling	1993	6,504	671	9.7	671		6,035		44
45	Leasehold Improvement-sign	1994	261	22	12	22		174		45
46	Leasehold Improvement-dryvit	1995	443	44	10	44		310		46
47	Leasehold Improvement-new ac	1999	723	48	15	48		145		47
48	Leasehold Improvement-roof	1985	972	51	19	51		870		48
49	Leasehold Improvement-roof	1994	863	58	15	58		460		49
50	Leasehold Improvement-roof	1997	819	55	15	55		273		50
51	Leasehold Improvement-roof	1998	1,390	93	15	93		371		51
52	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		22		52
53	Leasehold Improvement-hallway lighting	2001	155	16	10	16		16		53
54	Leasehold Improvement-DAI	2001	195	19	10	19		19		54
55										55
56	Related Party-AMS:									56
57	Leasehold Improvement-Remodeling	1993	4,266		7			4,266		57
58	Leasehold Improvement-Remodeling	1994	2,112	64	7	64		2,112		58
59										59
60	Realted Party Forum Pharmacy	1999	144	9	15	9		9		60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,739,284	\$ 106,825		\$ 90,221	\$ (16,604)	\$ 1,586,895		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 591,471	\$ 48,640	\$ 48,640	\$	5-15 yrs	\$ 243,136	71
72	Current Year Purchases	30,268	1,932	1,932		5-10 yrs	1,932	72
73	Fully Depreciated Assets	55,026	668	668			55,026	73
74	Related Party-Pharmacy	518	72	72		5-15 yrs	272	74
75	TOTALS	\$ 677,283	\$ 51,312	\$ 51,312	\$		\$ 300,366	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	van/bus	1998-2000	\$ 11,938	\$ 3,797	\$ 3,797	\$	3	\$ 6,200	76
77										77
78										78
79										79
80	TOTALS			\$ 11,938	\$ 3,797	\$ 3,797	\$		\$ 6,200	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,564,263	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 161,934	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 145,330	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,604)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,893,461	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 8,614 Description: Office copier

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Staff Transportation		\$ 725.00	\$ 7,250	17
18					18
19					19
20					20
21	TOTAL		\$ 725.00	\$ 7,250	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts	0			2,539		2,539	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12	Respiratory Therapy			35,207					35,207	12
13	Other (specify): Lab & Xray			0			282		282	13
14	TOTAL			\$ 35,207		\$	\$ 2,821		\$ 38,028	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 86,492	\$ 91,764	1
2	Cash-Patient Deposits	72,869	72,869	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	2,022,204	2,022,204	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,847	72,605	6
7	Other Prepaid Expenses	679	679	7
8	Accounts Receivable (owners or related parties)	1,159,777	1,677,215	8
9	Other(specify): <u>Miscellaneous receivables</u>	2,526	341,100	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,402,394	\$ 4,278,436	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		580,000	13
14	Buildings, at Historical Cost		3,414,649	14
15	Leasehold Improvements, at Historical Cost	454,788	454,788	15
16	Equipment, at Historical Cost	252,168	616,168	16
17	Accumulated Depreciation (book methods)	(409,399)	(778,721)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,001,380	21
22	Other Long-Term Assets (spe <u>Financing fees</u>)		211,762	22
23	Other(specify): <u>Deferred taxes</u>	81,868	81,868	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 379,425	\$ 5,581,894	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,781,819	\$ 9,860,330	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,258,779	\$ 2,258,779	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	121,237	121,237	28
29	Short-Term Notes Payable		47,572	29
30	Accrued Salaries Payable	221,867	221,867	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,027	41,027	31
32	Accrued Real Estate Taxes(Sch.IX-B)		46,881	32
33	Accrued Interest Payable		35,232	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>IDPA Assessments</u>	496,271	496,271	36
37	<u>Miscellaneous liabilities</u>	2,381	2,381	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,141,562	\$ 3,271,247	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,824,365	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,824,365	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,141,562	\$ 9,095,612	46
47	TOTAL EQUITY (page 18, line 24)	\$ 640,257	\$ 764,718	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,781,819	\$ 9,860,330	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 113,651	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 113,651	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	526,606	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 526,606	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 640,257	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,895,920	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,895,920	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,750	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,750	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		64	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 64	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,901,734	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,175,169	31
32	Health Care	2,641,892	32
33	General Administration	1,657,467	33
B. Capital Expense			
34	Ownership	813,851	34
C. Ancillary Expense			
35	Special Cost Centers	44,049	35
36	Provider Participation Fee	355,774	36
D. Other Expenses (specify):			
37	Less: Related party salary allocations-AMS	(287,761)	37
38	Less: Related party salary allocations-Forum	(369)	38
39	Less: Related party salary allocations-Pyramid	(24,944)	39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,375,128	40
41	Income before Income Taxes (line 30 minus line 40)**	526,606	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 526,606	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Available If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/2001

Ending:

12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	1,011	1,035	\$ 32,568	\$ 31.47	1
2 Assistant Director of Nursing	2,964	3,148	90,449	28.73	2
3 Registered Nurses	20,713	22,437	562,213	25.06	3
4 Licensed Practical Nurses	10,268	11,117	233,046	20.96	4
5 Nurse Aides & Orderlies	126,211	129,351	1,180,454	9.13	5
6 Nurse Aide Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides					8
9 Activity Director	1,584	1,824	32,637	17.89	9
10 Activity Assistants	1,943	1,992	16,951	8.51	10
11 Social Service Workers					11
12 Dietician					12
13 Food Service Supervisor	1,904	2,080	33,188	15.96	13
14 Head Cook	6,604	6,908	53,001	7.67	14
15 Cook Helpers/Assistants	9,831	10,292	72,693	7.06	15
16 Dishwashers					16
17 Maintenance Workers	1,888	2,080	39,759	19.11	17
18 Housekeepers	15,231	16,318	153,999	9.44	18
19 Laundry	6,164	6,687	82,904	12.40	19
20 Administrator					20
21 Assistant Administrator					21
22 Other Administrative	1,944	2,080	57,445	27.62	22
23 Office Manager					23
24 Clerical	4,749	4,966	52,977	10.67	24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)	872	896	12,923	14.42	28
29 Resident Services Coordinator	5,040	5,328	72,473	13.60	29
30 Habilitation Aides (DD Homes)					30
31 Medical Records					31
32 Other Health Care(specify)					32
33 Other(specify) Personnel	572	853	15,002	17.59	33
34 TOTAL (lines 1 - 33)	219,493	229,392	\$ 2,794,682 *	\$ 12.18	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant		\$		35
36 Medical Director	monthly	29,660	9	36
37 Medical Records Consultant				37
38 Nurse Consultant				38
39 Pharmacist Consultant	monthly	2,616	10	39
40 Physical Therapy Consultant				40
41 Occupational Therapy Consultant	518	26,687	10A	41
42 Respiratory Therapy Consultant				42
43 Speech Therapy Consultant				43
44 Activity Consultant	71	3,663	11-3	44
45 Social Service Consultant	45	2,336	12-3	45
46 Other(specify)				46
47 Physical Rehab	1,127	58,043	10A	47
48				48
49 TOTAL (lines 35 - 48)	1,761	\$ 123,005		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses		\$ N/A		50
51 Licensed Practical Nurses				51
52 Nurse Aides				52
53 TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Alden Village Health Facility

0038455

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description			Description		
Agpasa(2704)/Dalicandro(2414)	administrator	0	\$ 5,119	Workers' Compensation Insurance	\$ 39,641		IDPH License Fee	\$	
various executives	management	0	41,461	Unemployment Compensation Insurance	38,869		Advertising: Employee Recruitment		(401)
Dipaolo(4915)/Glantz(817)	administrator	0	5,732	FICA Taxes	222,889		Health Care Worker Background Check		
Palazzo(2666)/Weber(2383)	administrator	0	5,049	Employee Health Insurance	49,424		(Indicate # of checks performed _____)		
Taylor	administrator	0	48,156	Employee Meals	22,042		Misc. dues/subscriptions		174
	administrator	0		Illinois Municipal Retirement Fund (IMRF)*			Illinois Health Care Association		4,270
	administrator	0		Employee Vaccination costs	5,998		Secretary of State		50
				Miscellaneous costs	3,116		Village of Bloomingdale/Dupage Cty		725
				Employee match-401k	1,317		HCFA Laboratory Certificate		300
							related party-ams		194
							Less: Public Relations Expense	(
							Non-allowable advertising	(
							Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 105,518				TOTAL (agree to Sch. V,	\$	5,312
(List each licensed administrator separately.)							line 20, col. 8)		
B. Administrative - Other				TOTAL (agree to Schedule V,			line 22, col.8)		
				\$ 423,833					
Description				Amount					
TOTAL (agree to Schedule V, line 17, col. 3)				\$					
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Alden Management Services< inc.	Management fees	\$ 524,024					Out-of-State Travel	\$	
Kenneth Fisch	Legal	8,872							
Barry H Greenburg	Legal	8,159					In-State Travel		
Janet Hermann	Legal	2,773					Administrator/staff reimbursement		1,868
US Gas & Energy	Natural Gas & Electric Cons.	981							
American National Bank	Trust fees-Real estate	1,235					Seminar Expense		1,103
Bennbrook	DD Consulting	144,000							
MediCom	Computer Services	272					related party-ams		7,982
Blackman Kallick	Audit/Tax services	3,200					Entertainment Expense	(
							(agree to Sch. V,		
							line 24, col. 8)	\$	10,953
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 693,515						

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Wash Condenser	5/93	\$ 3,238	10	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 108	\$	\$
2	Circulator pump	11/94	2,100	10	210	210	210	210	210	210	210	175	
3	Compressor A/C	11/94	2,191	15	146	146	146	146	146	146	146	146	146
4	Circulator Pump	1/95	1,621	10	162	162	162	162	162	162	162		
5	Relocating water pipe	7/95	1,908	15	127	127	127	127	127	127	127	127	127
6	Rooftop repair	9/96	3,545	10	354	354	354	354	354	354	354	354	354
7	Repair A/C	6/98	3,650	3	709	1,217	1,217	507					
8	Replace blowers	10/98	2,620	3	218	873	873	655					
9	replace blowers	10/98	2,115	3	176	705	705	529					
10	Thermometor on heater	8/99	1,502	3		209	501	501	292				
11													
12	Reapir water main and tie	5/00	1,572	3			349	524	524	175			
13	Repair CAT equip	11/00	1,855	3			103	618	618	515			
14	General repairs	7/01	1,550	3				215	517	517	302		
15	RPZ reapir and cert	7/01	2,781	3				386	927	927	541		
16	General repairs	9/01	1,766	3				147	589	589	441		
17	General Maintenance	11/01	2,362	3				66	787	787	721		
18													
19													
20	TOTALS		\$ 36,376		\$ 2,427	\$ 4,327	\$ 5,071	\$ 5,471	\$ 5,577	\$ 4,833	\$ 3,112	\$ 802	\$ 627

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,708 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 355,774
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,042 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: BDO Seidman, LLP. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.